Ready to bleed when touched – Moral Injury in the Special Operations Forces military population

Abstract: The armed forces combine different military populations with specific patterns of psycho-medical challenges and needs. The Special Operations Forces (SOF) exhibit one such pattern because they undergo more rigorous selection procedures, train differently and generally engage in different types of missions than other military populations. The aim of this commentary is to briefly introduce the psycho-medical patterns of SOF while paying particular attention to the growing discussion of Moral Injury (MI) in this military population. The mental health construct of MI refers to the persistent psycho-social harm resulting from exposure to events that clash with an individual’s moral beliefs. So far, research has focused on causes and symptoms of MI, less on prevention strategies and early intervention opportunities. This article advocates making a regular screening for symptoms of MI an element of routine physical check-ups of SOF to identify MI-related problems earlier and destigmatise mental health struggles, thereby countering severe manifestations of MI and alleviating suicidality rates in the SOF military population.

Keywords: Special Operations Forces, mental health, military population, injury patterns, operator syndrome, mental illness stigma

1 Special Operations Forces (SOF) as a military population

Most countries around the globe rely on SOF and define them as a military force that is specially selected, trained and equipped to conduct missions that conventional forces cannot perform, thereby serving a high-level combat and national security role [1]. The SOF portfolio includes covert operations often in hostile and/or politically sensitive areas, far from operational bases and medical support [2,3]. Governments also task SOF with peace missions because they oftentimes provide a more economic, dynamic and robust option compared to conventional forces [4]. Despite their numerous roles and contribution to (inter-)national security, SOF remain an understudied military population [1,5]. This commentary aims to introduce some psycho-medical patterns that have been documented in SOF personnel, while paying particular attention to the mental-health challenges related to Moral Injury (MI) and suicidality in this military population.

SOF selection, training and missions result in a notably high allostatic load [6]. SOF tend to deploy with a higher frequency and duration than conventional forces [2,7]. Not only their deployments but also training includes dangerous activities. Heavy weapon use, diving on 100% oxygen, parachuting and breaching secured buildings using explosives put SOF at a sustained risk of multiple physical injuries and comorbidities. SOF’s specific injury pattern combines traumatic brain injury, musculoskeletal overuse injury and a higher prevalence of comorbid conditions than seen in conventional military forces [8–12]. Studies suggest that SOF personnel endure higher rates of chronic pain, osteoarthritis, hyperlipidaemia, fractures (hip, wrist and spine) and obstructive sleep apnoea relative to non-SOF [12]. Because the SOF military population exhibits a specific pattern of adverse medical consequences some researchers use the term “Operator Syndrome” and include psychological and behavioural challenges common to SOF personnel such as, for example, worry, rumination, anger and civilian community dysfunction [6].

Nevertheless, the SOF population reports fewer mental and physical health problems compared with conventional forces [1,2]. However, this does not necessarily mirror the actual incidence rate of psycho-medical challenges. Instead, underreporting appears to be closely linked to the culture of SOF. Operators rely on an intricate psycho-physical concept of the “SOF warrior” to conceptualise a sense of self that allows them to carry out frequent and dangerous missions [13]. They emphasise their physical hardness as well as their mental strength [7,14–16]. This conceptualisation can prompt them to interpret mental
health issues as a weakness and, thus, as something unsettling and not to be shared with others [17]. The culture of the SOF military population emphasises mission accomplishment and small-group cohesion, incentivising individuals to ignore and suppress their own mental health struggles for the sake of their unit and the mission [18,19]. Additionally, mental health problems can result in the suspension of operators' security clearances, which are critical for military members' experience in conflict zones because it makes them feel that by ensuring an annual [Personal Stress] evaluation along with the physical checkup, the mental check-up becomes a routine and is not seen as the dreaded visit to the mental health clinic" [17].

2 Moral Injury

It is against this background that MI presents a challenge in the SOF population. MI refers to the debilitating and persistent psychological distress that individuals can develop when they violate their own moral norms and expectations through specific (in)actions – or are exposed to actions on the part of another (trusted) individual, group or authority that violate and betray their moral values [20–22]. MI is usually preceded by a Potentially Morally Injurious Event/Experience (PMIE) [21,23,24]. Following a PMIE, cognitive appraisals take place: Individuals tend to question their actions – and/or inactions – during the event and deliberate what their event-related behaviours say about them [25]. These appraisals become maladaptive and are accompanied by cognitive processes such as rumination, ultimately leading the individuals to believe, for instance, that they are immoral or evil human beings [21]. These cognitions can lead to, or are accompanied by, transdiagnostic feelings. Hallmark feelings include (survivor’s) guilt, shame and (self-)-betrayal [21]. Maladaptive behaviours can ensue and include self-deprecation, self-sabotaging, substance abuse, aggression, social alienation, functional impairment and suicide [20–26].

Severe MI can resemble post-traumatic stress disorder (PTSD), for instance, through suicidal ideation. Although similar to PTSD, MI also differs in important ways. For example, fear appears to play a significantly lesser and limited role in MI relative to PTSD [27,28]. Furthermore, PTSD appears to be accompanied by descriptive cognitions that can be objectively countered (e.g. it is not safe to be here; the person in front of the supermarket is an enemy combatant), whereas prescriptive cognitions underlie MI and are more difficult to counter (e.g. we should not have done this; I could have rescued the civilian) [29]. The construct of MI has been considered important for the understanding of military members’ experience in conflict zones because it includes ethical and sociological perspectives [30].

3 MI in SOF

In his novel The Count of Monte Cristo, the French author Alexander Dumas wrote almost 180 years ago: “Moral wounds have this peculiarity, – they may be hidden, but they never close; always painful, always ready to bleed when touched, they remain fresh and open in the heart” [31]. Last year, Ingerson et al. used Dumas’ observation to introduce their work on MI in the US SOF community [32]. According to the authors, MI “is the catalyst for a sharp increase in suicide, meaning it not only needs to be dealt with, but dealt with now” [32]. MI is not included in the Diagnostic and Statistical Manual of Mental Disorders (DSM-5-TR) or the International Classification of Diseases (ICD-11). Somewhat paradoxically, this fact may have an encouraging effect on some SOF operators because it means that it is not mandatory for military mental health providers to report incidents of MI. This can potentially make it easier for SOF personnel to come forward and seek help.

Writing about rising mental health problems in the SOF population, US SOF officer Derek Price proposes a Personal Stress Index consisting of two scales [17]. The first one would provide a numerical acute-and-chronic stress score, the other a numerical coping mechanism score. According to Price, the ability to move up and down on the scales could contribute to normalising stress-related fluctuations and mental health challenges across the SOF military population. Price suggests embedding the evaluation into the SOF annual physical check-up [17]. One of several strengths of Price’s idea is “that by ensuring an annual [Personal Stress] evaluation along with the physical checkup, the mental check-up becomes a routine and is not seen as the dreaded visit to the mental health clinic” [17]. This approach, Price argues, could stop the current “system that assigns a disorder to certain [SOF] members because they can’t seem to thrive like fellow members of the unit” [17].

Although Price focuses on the prevention of PTSD and leaves numerous questions open, his concept is valuable in the context of MI. Mental health care providers to the SOF population could use existing inventories with high psychometric properties such as, for example, the Moral Injury Events Scale, the Moral Injury and Distress Scale and the Moral Injury Outcome Scale as part of a regular physical examination. These scales can help to identify exposure to PMIEs, assess the presence and severity of MI symptoms and offer insights into the functional impairment resulting from the symptoms [33–35]. Other MI-related scales are also available, such as the Moral Injury Questionnaire – Military Version [28].

In the SOF population, even low-level moral distress should not be ignored as it can impact lives and national
security. That is one of the reasons why a stronger prophylactic approach to SOF mental health has been recommended [36]. Embedding an MI-related questionnaire into a regular physical examination would allow (mental) health care providers to screen for early signs of MI before it assumes a severe manifestation. It would also follow the advice of mental health care providers in the SOF community who emphasise avoiding compartmentalisation of MI as a purely psychological or medical issue [32]. And, as Price rightly suggests, it could contribute to destigmatising mental health-related challenges: If the SOF population accepts mental health-related questionnaires as a routine when they do not experience psychological challenges, they may approach them with more candour when they do run into MI-related challenges. Admittedly, SOF culture with its emphasis on strength and hardiness may pose an obstacle – which raises, and invites an interdisciplinary approach, to the question how to train, educate and deploy SOF in ways that do not prompt them to keep secret their wounds, particularly the ones “ready to bleed when touched.”

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References


